Peninsula
UNDERWRITING • LTD

CORPORATE HEALTH PROVIDERS PROPOSAL FORM

Please read the following questions carefully and answer them all providing additional information where required. Should you require more space please provide answers on a separate sheet of paper.

Answer the question using BLOCK CAPITALS and tick boxes where appropriate.

1. PROPOSER'S DETAILS

Full Name of Proposer

Address of Proposer

Trading address if different from above:

Contact details (tel, fax, e-mail, website)

Date Proposer established

Has the Insured or its principles engaged in any Healthcare activities under a different title in the last five years. If so, please provide details on a separate sheet identifying trading and registered address, nature of services.

YES ☐ NO ☐

Please name the ultimate Owner or Holding Company:

Please identify any corporate or private entity of either USA or Canadian origin, that has any ownership or interest in either the Proposer or the Proposer's ultimate owner or holding company and their percentage holding.

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2: THE BUSINESS

Please state your total Gross Fee Income / Turnover / Gross Receipts:

For the past financial year
Estimate for the current financial year

Please give a full description of your business activities for which cover is required (this must be answered):

Pleas tick if you are involved in any of the following and where indicated*, complete the relevant Addendum.

		% TOTAL INCOME
Assisted Conception Unit*		
Autologous Bloodbank		
Clinical Research Establishment*		
Health and Fitness Centre/Gym*		
Industrial/Occupational Health & Safety*		
Health Screening Centre/Mobile Unit*		
Inoculation/Travel Centre		
Medical Personnel/Employment Agency*		
Medical teaching facility		
Nursing teaching facility		
Pathology Laboratory*		
Repatriation &/or Ambulance Service*		

What, if any, substantial changes in your activities or major new developments are likely to occur within the next 12 months? Please give full details.

Are you licensed and registered in accordance with the applicable regulatory body or law to practice those procedures at the address specified in Question 3 for which indemnification is required?

YES ☐ NO ☐

If NO please give full explanation why not:

Please identify your memberships or registration with Association or Professional Bodies or Licensing Authorities

Has membership of or registration with such, ever been suspended, withdrawn, amended, declined or had conditions attached?

YES ☐ NO ☐

If YES please give full details.

Do you ensure and record that at all times all Registered Medical and Dental Practitioners are members of a Medical/ Dental Defence Organisation, recognised by your National Medical/Dental Association, or are otherwise fully Insured for their own Malpractice?

YES ☐ NO ☐

Please state the total number of persons involved in the following capacities:

Psychiatrists		
Other		
Cosmetic		
Orthopaedic		
Anaesthetists		
Obstetricians		
Gynaecologists		
Lab/Path technicians		
Dentists		
Midwives		
Nurse Anaesthetists		
Nurses - Day		
Nurses - Night		
Pharmacists		
Paramedics		
Resident Medical Officers		
Complementary Professionals		
Supplementary Professionals		
Auxiliaries - Day		
Auxiliaries - Night		
Counsellors		
Directors/Partners/Principals		
Clerical/Administration		
Other (please specify)		

Are any counselling services made available to patients?

YES ☐ NO ☐

If YES please indicate in which of the following categories:

	NUMBER OF COUNSELLORS	EMPLOYED	SELF-EMPLOYED	NUMBER OF PATIENTS
Assisted Conception				
Drug/Alcohol Dependency				
Elective Cosmetic				
Elective T.O.P				
Gender Reassignment				
HIV/HEP/STD				
Sterilisation				
Other (please specify)				

Do all Counsellors hold appropriate qualifications?

YES ☐ NO ☐

Please provide details

Does any person involved in the treatment and care of any patient suffer from any disability, transmittable diseases i.e Hepatitis, H.I.V. etc. or other impediment which may affect the performance of his/her professional duties or place patients/clients at risk?

YES ☐ NO ☐

If YES what procedures are in place:

Please state:

Total number of Day Care beds:

Total number of Overnight beds:

What, if any, percentage of patients/clients in the last year came from USA or Canada:

Please state what, if any, percentage of the patients/clients in the last year who may be resident in Britain come from USA or Canada:

Do you provide facilities for the sterilisation of instruments in accordance with current guidelines?

YES ☐ NO ☐

If NO please provide details of what arrangements are in place for this:

If YES do you ensure that effective cross-infection control methods are employed?

Do you have a protocol for needlestick injuries?

YES ☐ NO ☐

If NO please give full details

Please give full details of what records are kept, where and how they are stored and for how long they are retained:

Please note that it is a requirement of this policy that all records are retained for a minimum period of 10 years, and in the case of minors, 10 years from majority.

3. INSURANCE COVER

Has the Proposer previously purchased Professional Indemnity Insurance?
YES ☐ NO ☐

If YES please provide the following information:

Name of Insurers:
Expiry Date:
Indemnity Limit:
Deductible:
Retroactive Date:

Has an insurer ever:
Declined a proposal or a renewal for this insurance?
YES ☐ NO ☐

Imposed special terms or increased premium other than standard market increases?
YES ☐ NO ☐

Cancelled the insurance?
YES ☐ NO ☐

If YES to any of the above questions please provide details below:

What is the limit of indemnity you now require:

What is the deductible you now require:

4. CLAIMS INFORMATION

Is the Proposer aware of any fraud, dishonesty, bankruptcy or administration order applicable to the Proposer and/or any past or present principal, partner, director or employee?

YES ☐ NO ☐

If YES please provide details:

Has any claim been made against the Proposer's business or against any principal, partner, director or employee whilst in this or any other business?

YES ☐ NO ☐

If YES please provide details:

Is the proposer aware of any circumstance or incident which has or could result in any claim being made against the Proposer's business, or against any principal, partner, director or employee whilst in this or any other business?

YES ☐ NO ☐

If YES please provide details:

5. DECLARATION

I/we declare and warrant that after enquiry all statements and particulars contained in this Proposal and addenda are true and that no information whatsoever has been withheld which might increase the risk of the Underwriters or influence the acceptance of this Proposal and should the above particulars alter in any way I/We will advise Underwriters as soon as is practicable.

I/We understand that failure to disclose any material facts which would influence the acceptance and assessment of the Proposal may result in the Underwriters refusing to provide indemnity or voiding the possibility in every respect.

I/We hereby agree and accept that this Declaration shall be the basis of the contract between both parties if entered into.

SIGNATURE

POSITION

NAME

DATE

ADDENDUM 1 - ASSISTED CONCEPTION

If an assisted conception unit is maintained, please give full percentage breakdown of the number of cycles undertaken:

A.I.H	
A.I.D	
I.V.F / E.T / P.R.O.S.T	
FROZEN EMBRYO REPLACEMENT	
G.I.F.T	
OTHERS - please specify and indicate numbers	

Are counselling services made available to patients?

YES ☐ NO ☐

Is all donor semen screened, cryopreserved and quarantined in line with current recommendations?

YES ☐ NO ☐

ADDENDUM 2 - CLINICAL TRIALS

Please state for whom Clinical research Projects are undertaken e.g. pharmaceutical and manufacturers, Charities, Research Foundations etc

Do you receive a full indemnity from your Principals?

YES ☐ NO ☐

Do all volunteers sign an Informed Consent Form?

YES ☐ NO ☐

If double blind studies are undertaken are volunteers made fully aware of this?

YES ☐ NO ☐

Do any trials involve and female volunteers of child-bearing age?

YES ☐ NO ☐

If YES please provide full details:

Please state the Annual Income or Turnover

Please state the number of trials during the past 12 months detailing the number of volunteers:

Please state the anticipated number of trials with which you will be involved during the next 12 months detailing the number of volunteers in each trial:

Do you conduct any formal research, testing or experimental activities in the following categories:

Transplant ☐
Artificial Organ ☐
Surgery ☐
Human Embryo Research ☐
Genetic Engineering ☐
Obstetrics ☐

YES ☐ NO ☐

ADDENDUM 3 - HEALTH & FITNESS CENTRES

Please state the approximate percentage of your income within the following categories:

Gym / Exercise	%
Diet / Nutrition	%
Sunbeds / Solarium	%
Hairdressing	%
Beauty Therapy	%
Electrolysis	%
Ear Piercing	%
Other (please specify):	%

Please state the number and type of Complimentary Therapists:

PLEASE ENCLOSE A COPY OF ANY OR ALL QUESTIONNAIRES THAT CLIENTS MUST COMPLETE PRIOR TO TREATMENT. IF THERE IS NONE STATE 'NONE'.

ADDENDUM 4 - INDUSTRIAL/OCCUPATIONAL HEALTH

Is your work solely 'in-house' i.e. limited to other divisions or companies with common ownership to yourselves?

YES ☐ NO ☐

If NO please give full details of other companies for whom work is undertaken:

Please give full details of any outpatient or other medical facilities made available to staff:

Is health screening made available?

YES ☐ NO ☐

IF 'YES' PLEASE COMPLETE THE FOLLOWING ADDENDUM.

ADDENDUM 5- HEALTH SCREENING

Please give an approximate percentage breakdown of your patients between the following categories:

Insurance Medicals	
General Fitness Assessment	
Well Woman/ Well Man	
A.I.D.S. testing	
Other (please specify):	

Do you have C.A.T / M.R.I scanners or similar?

YES ☐ NO ☐

If 'YES' please give details including date of purchase, details of any service contract or guarantee:

ADDENDUM 6 - MEDICAL PERSONNEL AGENCIES

What are the minimum acceptable qualifications and years of experience in respect of the following?

Nurses
Midwives
Other (please specify)

Are all staff vetted and references taken up?

YES ☐ NO ☐

If NO please give full details:

Do you ensure that all nurses and midwives supplied by you maintain membership of the R.C.N. or the R.C.M. or are otherwise insured for Medical Professional Liability?

YES ☐ NO ☐

ADDENDUM 7 - PATHOLOGY LABORATORIES

Do you administer any pathology laboratories in medical establishments outside your ownership?

YES ☐ NO ☐

If YES please give full details:

What procedures are in place to ensure that results are promptly received by whom they were requested?

Please give a percentage breakdown by Income between the following:

Human Pathology	%
Animal Pathology	%
Drug Testing	%
Other. Eg. Legionnaires/ Salmonella etc (please specify and give full details):	%

With Human Pathology, please confirm what percentage, if any, of your Income/ turnover/ gross receipts is derived from A.I.D.S testing. IF NONE STATE 'NONE'.

ADDENDUM 8 - REPATRIATION/ AMBULANCE SERVICES

Please state the:
Number of Ambulances in operation:

Number of crew members per ambulance:	
Minimum acceptable qualifications of crew members:	
Average number of routine trips to hospitals, nursing homes etc per annum:	

Is an Air Ambulance repatriation service maintained?
YES ☐ NO ☐

If YES please state:

In which country you anticipate operating:

The number of repatriations per annum:

Do you provide private Ambulance or First Aid at Public events?
YES ☐ NO ☐

If YES please give details of: The type and size of event for which services are provided:

The number of events per annum: